Certification for Youth Camps 2019

Prevention and Health Promotion Administration

Environmental Health Bureau

Center for Healthy Homes and Community Services

6 St Paul Street, Suite 1301

Baltimore, MD 21202

Phone 410-767-8417 Fax 410-333-8926

MARYLAND Department of Health

MISSION AND VISION

MISSION

The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

VISION

The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

CHHCS Staff

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</table>

MARYLAND Department of Health

Legal Authority/Regulation

❖Law: Youth Camp Act:

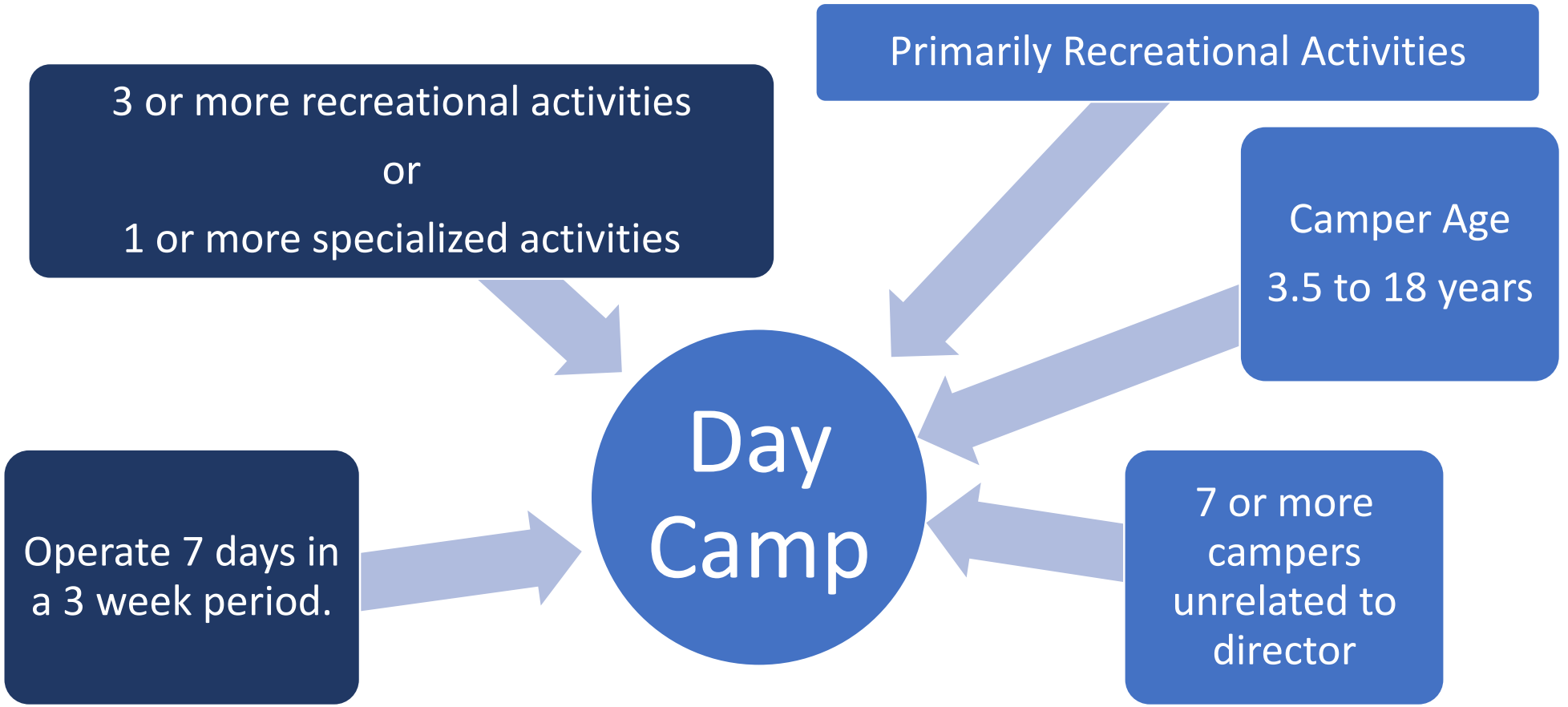
Health General Title 14 Subtitle 4

- Regulation: COMAR 10.16.06
  - Updated in 2016
- Regulation: COMAR 10.16.07
  - Created in 2016
- Regulation: COMAR 10.01.17
  - Update in 2016

Is My Program a "Youth Camp"?

Day Camp

COMAR 10.16.06.02B(13)

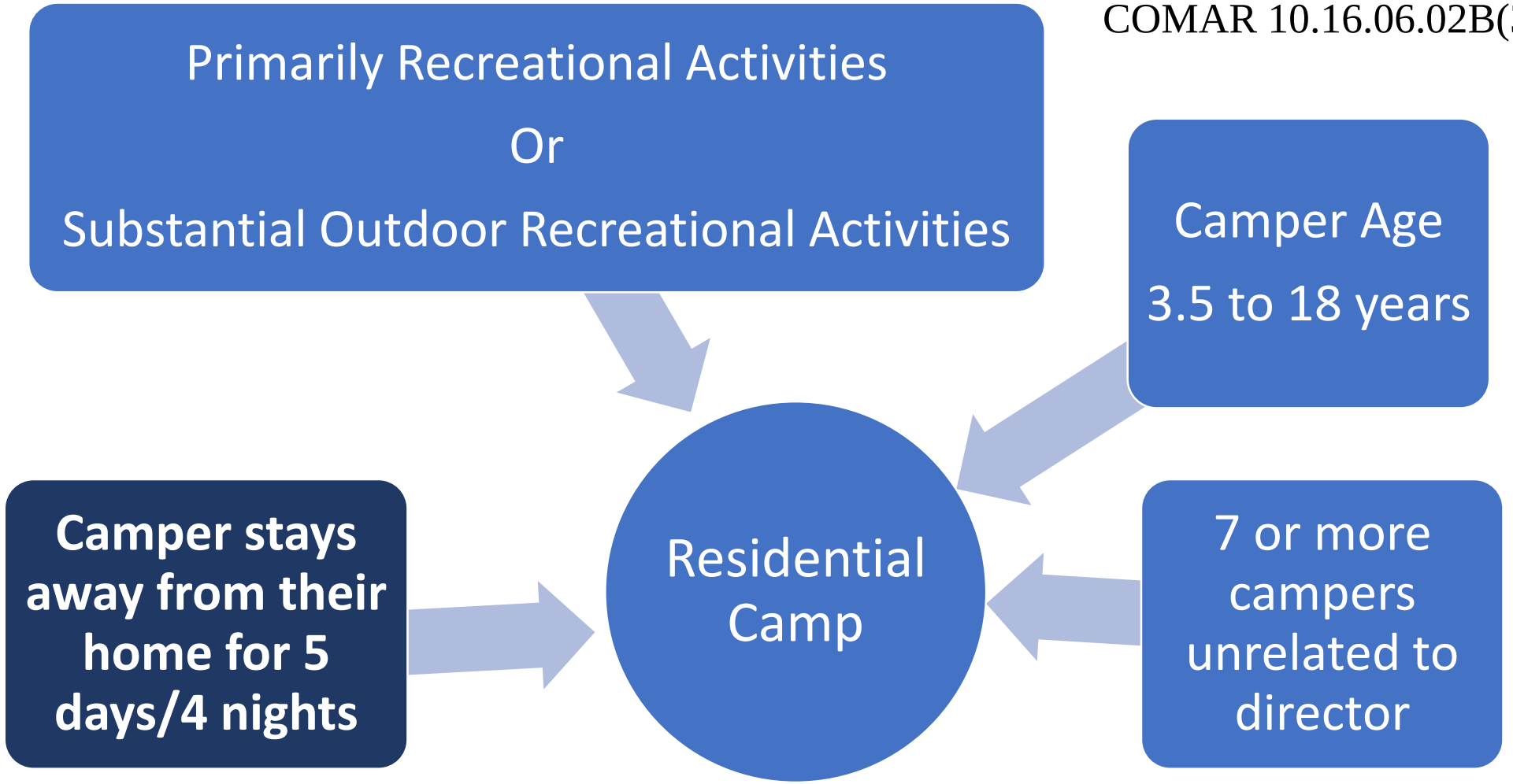


MARYLAND Department of Health

Is My Program a "Youth Camp"?

Residential Camp

COMAR 10.16.06.02B(30)



MARYLAND Department of Health

What Is NOT a Youth Camp?

COMAR 10.16.06.02B(39)(c)

- A licensed child care center
- A family day care home
- A program operating before or after a daily school session
- A competitive activity sponsored by a sports league
- An instructional program of 2 hrs. or less in a specialized activity

What Is NOT a Youth Camp?

COMAR 10.16.06.02B(39)(c)

- A summer school program taught by certified teacher and offering credit
- A program or activity where parents/guardians are present for duration, participate, and oversee activities of the child

What Is NOT a Youth Camp?

COMAR 10.16.06.02B(39)(c)

- A program enrolling children under the age of 3.5 years old cannot be licensed as a youth camp.
  - The operator should consult with Child Care Administration to see if a child care license is required.

New Application

COMAR 10.16.06.08

- New Youth Camp Application
  - Print from Youth Camp website
  - https://phpa.health.maryland.gov/OEHFP/CHS/Shared%20Documents/Youth%20Camps/ApplicationforNewYouthCamp.pdf
  - Fill out completely, accurately, attach all required supporting documents, & fee
- Renewal Applications
  - Renewal email are sent to operator
  - "Good Standing"- Pay reduced fee
- Applications not signed, submitted without fee, or with incorrect fee will not be reviewed and will be returned.

Fee Chart

COMAR 10.01.17.02B

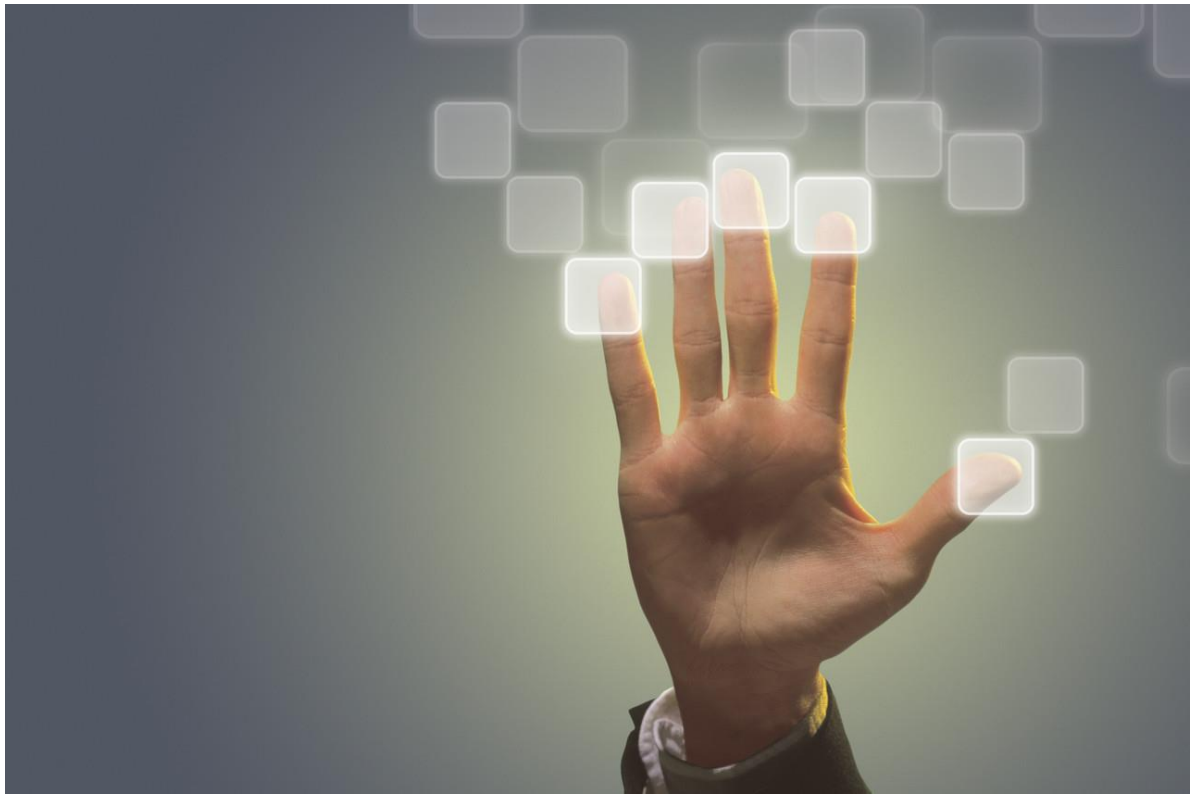
Maryland Department of Health		
Center for Healthy Homes and Community Services		
Youth Camp Application Fee Chart		
Effective January 1, 2017		
Day Camps		
Camper Days	Regular Fee	Reduced Fee
1 to 500	$190	$45
501 to 2,000	$500	$125
2,001 to 5,000	$665	$165
5,001 or more	$855	$215
Residential, Day & Residential, Trip, or Travel Camps		
Camper Days	Regular Fee	Reduced Fee
1 to 700	$500	$125
701 to 5,000	$1,000	$250
5,001 to 16,000	$1,500	$375
16,001 or more	$2,000	$500

Renewal Application

COMAR 10.16.06.08

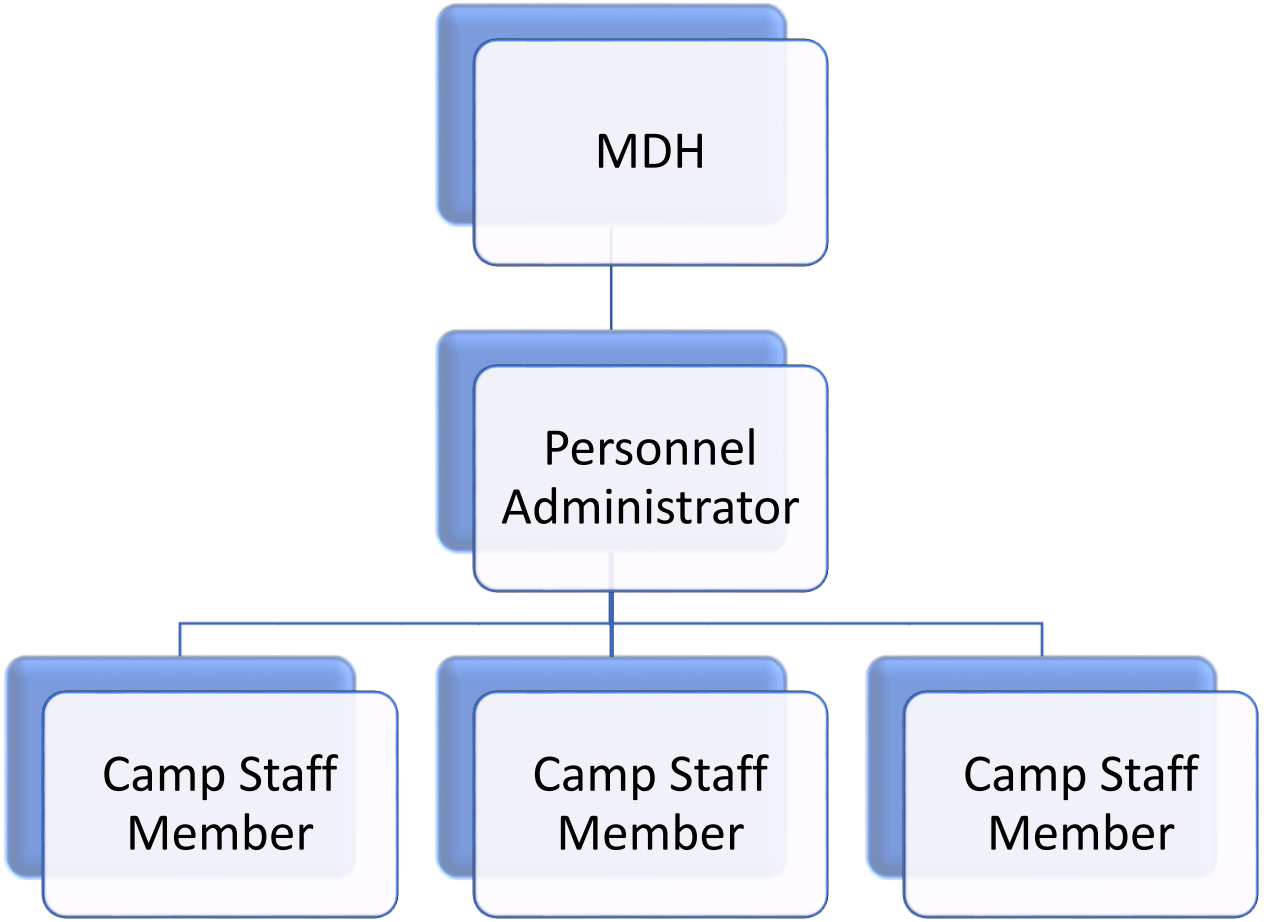
- Renewal Applications
  - Renewal email is sent to operator
  - "Good Standing"- Pay reduced fee
    - Application submitted on time
    - Annual Report submitted on time
    - All fees paid
    - No Critical Violations for 2 years
    - Self-Assessment submitted on time
- Applications not signed, submitted without fee, or with incorrect fee will not be reviewed and will be returned.

COMAR 10.16.06.21



MARYLAND Department of Health

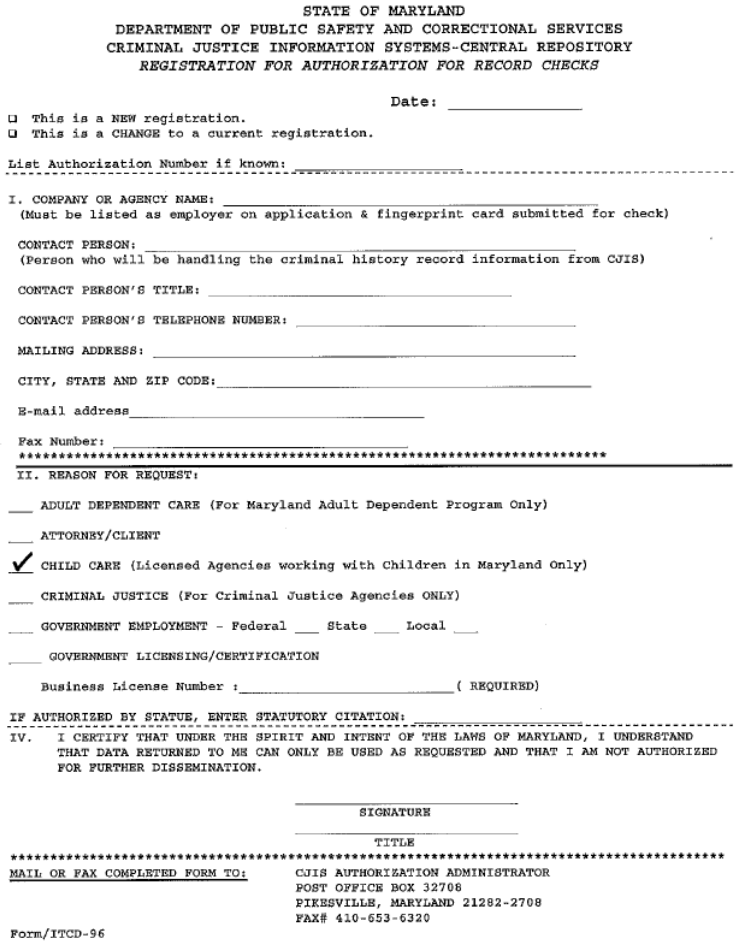
COMAR 10.16.06.21



MARYLAND Department of Health

Authorization Number

- Camp applies for Authorization Number through **CJIS**
- Results are sent to contact person
- Email notification
- View/print results from secure web site



STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS-CENTRAL REPOSITORY
REGISTRATION FOR AUTHORIZATION FOR RECORD CHECKS

Date: _____

☐ This is a NEW registration.
☐ This is a CHANGE to a current registration.

List Authorization Number if known: _____

I. COMPANY OR AGENCY NAME: _____
(Must be listed as employer on application & fingerprint card submitted for check)

CONTACT PERSON: _____
(Person who will be handling the criminal history record information from CJIS)

CONTACT PERSON'S TITLE: _____

CONTACT PERSON'S TELEPHONE NUMBER: _____

MAILING ADDRESS: _____

CITY, STATE AND ZIP CODE: _____

E-mail address _____

Fax Number: _____

****

II. REASON FOR REQUEST:

___ ADULT DEPENDENT CARE (For Maryland Adult Dependent Program Only)

___ ATTORNEY/CLIENT

✓ CHILD CARE (Licensed Agencies working with Children in Maryland Only)

___ CRIMINAL JUSTICE (For Criminal Justice Agencies ONLY)

___ GOVERNMENT EMPLOYMENT - Federal ___ State ___ Local ___

___ GOVERNMENT LICENSING/CERTIFICATION

Business License Number : _____ (REQUIRED)

IF AUTHORIZED BY STATUE, ENTER STATUTORY CITATION: _____

IV. I CERTIFY THAT UNDER THE SPIRIT AND INTENT OF THE LAWS OF MARYLAND, I UNDERSTAND THAT DATA RETURNED TO ME CAN ONLY BE USED AS REQUESTED AND THAT I AM NOT AUTHORIZED FOR FURTHER DISSEMINATION.

_____
SIGNATURE

_____
TITLE

****

MAIL OR FAX COMPLETED FORM TO:
CJIS AUTHORIZATION ADMINISTRATOR
POST OFFICE BOX 32708
PIKESVILLE, MARYLAND 21282-2708
FAX# 410-653-6320

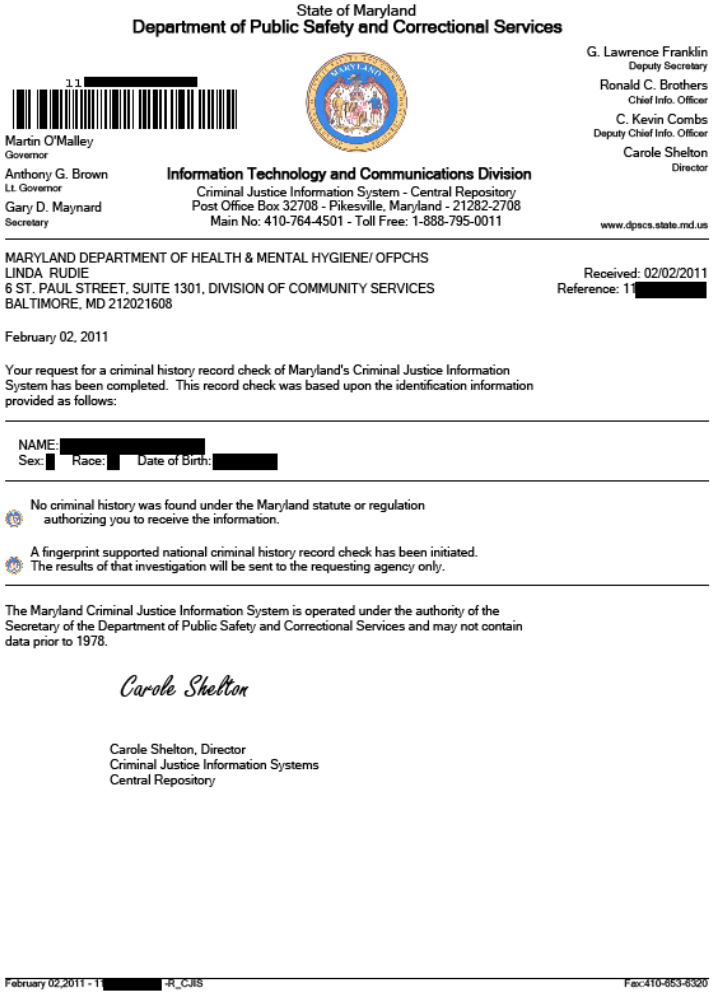
Form/ITCD-96

MARYLAND Department of Health

Maryland and FBI

- Must have completed MD & FBI check for all required employees
- "Employee" paid/compensated and has access to the campers
- Copy of results must be addressed to employer, not the employee

Results



State of Maryland
Department of Public Safety and Correctional Services

Martin O'Malley
Governor

Anthony G. Brown
Lt. Governor

Gary D. Maynard
Secretary

Information Technology and Communications Division
Criminal Justice Information System - Central Repository
Post Office Box 32708 - Pikesville, Maryland - 21282-2708
Main No: 410-764-4501 - Toll Free: 1-888-795-0011

G. Lawrence Franklin
Deputy Secretary

Ronald C. Brothers
Chief Info. Officer

C. Kevin Combs
Deputy Chief Info. Officer

Carole Shelton
Director

www.dpscs.state.md.us

MARYLAND DEPARTMENT OF HEALTH & MENTAL HYGIENE/ OFPCHS
LINDA RUDIE
6 ST. PAUL STREET, SUITE 1301, DIVISION OF COMMUNITY SERVICES
BALTIMORE, MD 212021608

Received: 02/02/2011
Reference: 11[redacted]

February 02, 2011

Your request for a criminal history record check of Maryland's Criminal Justice Information System has been completed. This record check was based upon the identification information provided as follows:

NAME:[redacted]
Sex:[redacted] Race:[redacted] Date of Birth:[redacted]

No criminal history was found under the Maryland statute or regulation authorizing you to receive the information.

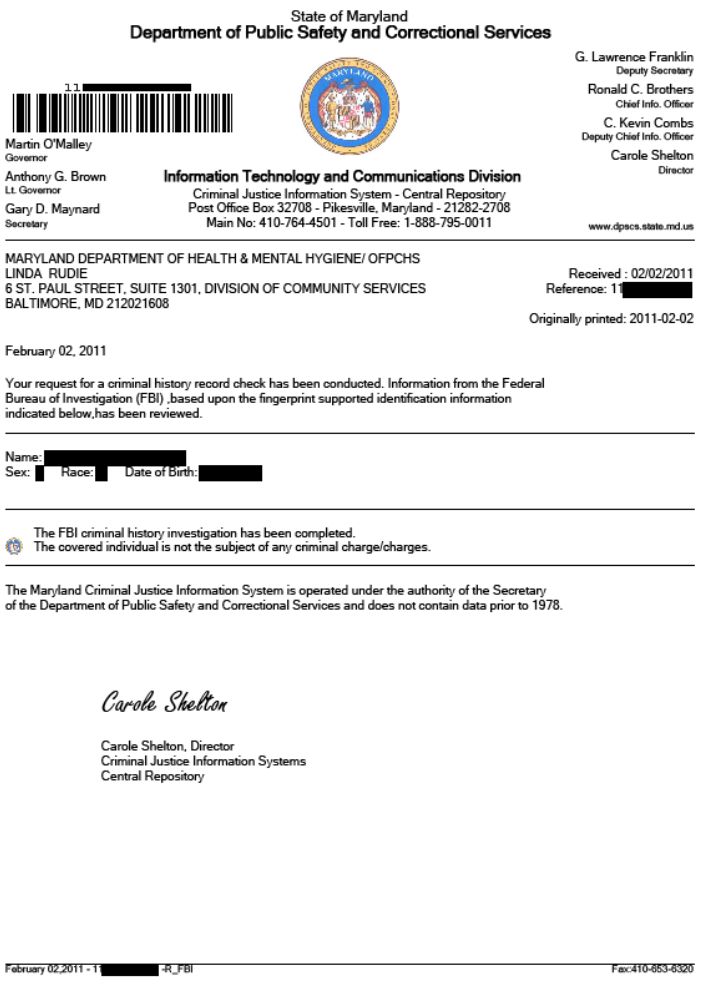
A fingerprint supported national criminal history record check has been initiated. The results of that investigation will be sent to the requesting agency only.

The Maryland Criminal Justice Information System is operated under the authority of the Secretary of the Department of Public Safety and Correctional Services and may not contain data prior to 1978.

Carole Shelton

Carole Shelton, Director
Criminal Justice Information Systems
Central Repository

February 02,2011 - 11[redacted]-R_CJIS Fax:410-653-6320



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MARYLAND DEPARTMENT OF HEALTH & MENTAL HYGIENE/ OFPCHS
LINDA RUDIE
6 ST. PAUL STREET, SUITE 1301, DIVISION OF COMMUNITY SERVICES
BALTIMORE, MD 212021608

Received : 02/02/2011
Reference: 11[redacted]

Originally printed: 2011-02-02

February 02, 2011

Your request for a criminal history record check has been conducted. Information from the Federal Bureau of Investigation (FBI) ,based upon the fingerprint supported identification information indicated below,has been reviewed.

Name:[redacted]
Sex:[redacted] Race:[redacted] Date of Birth:[redacted]

The FBI criminal history investigation has been completed.
The covered individual is not the subject of any criminal charge/charges.

The Maryland Criminal Justice Information System is operated under the authority of the Secretary of the Department of Public Safety and Correctional Services and does not contain data prior to 1978.

Carole Shelton

Carole Shelton, Director
Criminal Justice Information Systems
Central Repository

February 02,2011 - 11[redacted]-R_FBI Fax:410-653-6320

MARYLAND Department of Health

Fingerprints

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY

LIVESCAN PRE-REGISTRATION APPLICATION

APPLICANT INFORMATION *(PLEASE TYPE OR PRINT CLEARLY)*

Name:			
Date of birth:	SSN:	Gender: ☐ Male ☐ Female *(Please check)*	
Height: ft. inches	Weight: lbs.	Eye Color:	Hair Color:
Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American ☐ Other *(Please check)*			
Place of Birth:		Citizenship:	
Current address:			
City:		State:	ZIP Code: -
Daytime Phone:	Evening Phone:	Driver's License #:	

AGENCY INFORMATION

Agency Authorization #:	
ORI # (if required): MD004455Y	Reason fingerprinted? CHILD CARE
Position Applied for:	

Request Type: *(Choose one ONLY)*

- ☐ Adult Dependent Care
- ☐ Attorney/Client
- ☒ Child care
- ☐ Criminal Justice
- ☐ Gold Seal/ Adoption
- ☐ Gold Seal/Letter/VISA
- ☐ Government Employment
- ☐ Government Licensing or Certification
- ☐ Immigration/VISA
- ☐ Individual Challenge
- ☐ Individual Review
- ☐ MSP Licensing
- ☐ Private Party Petition
- ☐ Public Housing

Mail Response to:
(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name: _____

Address: _____

City, State, Zip code: _____

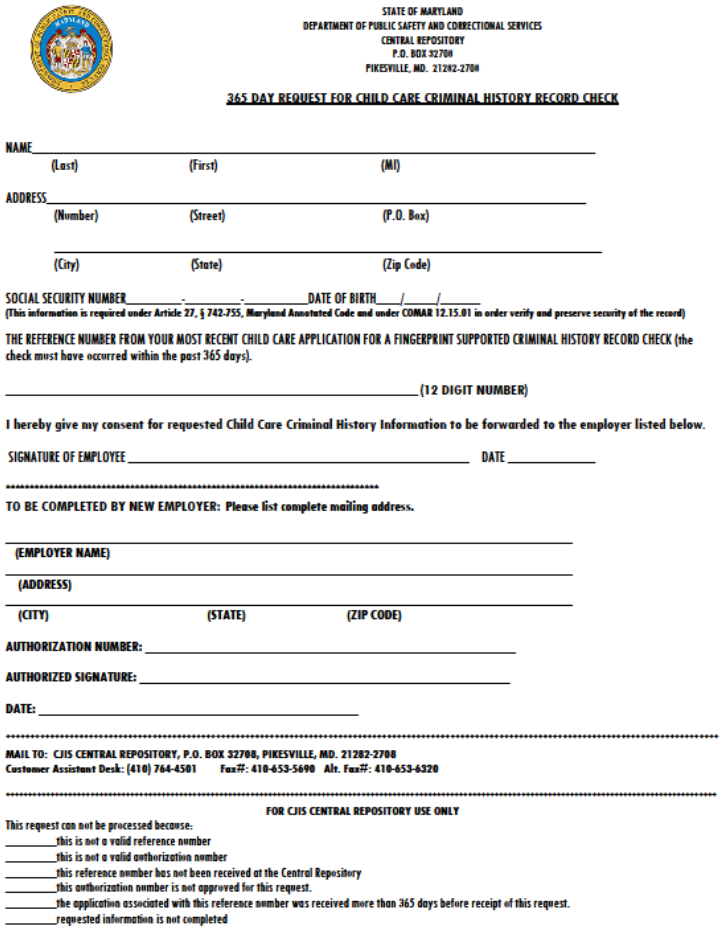
Maryland CJIS no longer accepts inked fingerprints as of April 15, 2012, except for out of state.
Use LIVESCAN PRE-REGISTRATION APPLICATION

MARYLAND Department of Health

Personnel Administrator

- MDH must have the personnel administrator's criminal background results from CJIS
- Use MDH Authorization Number: 9400019171
- ***DO NOT USE THIS AUTHORIZATION NUMBER FOR OTHER STAFF MEMBERS***

365 Day Request



STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CENTRAL REPOSITORY
P.O. BOX 32708
PIKESVILLE, MD. 21282-2708

365 DAY REQUEST FOR CHILD CARE CRIMINAL HISTORY RECORD CHECK

NAME_____
(Last) (First) (MI)

ADDRESS_____
(Number) (Street) (P.O. Box)

_____
(City) (State) (Zip Code)

SOCIAL SECURITY NUMBER_____-_____-_____DATE OF BIRTH____/____/_____
(This information is required under Article 27, § 742-755, Maryland Annotated Code and under COMAR 12.15.01 in order verify and preserve security of the record)

THE REFERENCE NUMBER FROM YOUR MOST RECENT CHILD CARE APPLICATION FOR A FINGERPRINT SUPPORTED CRIMINAL HISTORY RECORD CHECK (the check must have occurred within the past 365 days).

_____(12 DIGIT NUMBER)

I hereby give my consent for requested Child Care Criminal History Information to be forwarded to the employer listed below.

SIGNATURE OF EMPLOYEE _____ DATE _____

****

TO BE COMPLETED BY NEW EMPLOYER: Please list complete mailing address.

_____
(EMPLOYER NAME)
_____
(ADDRESS)
_____
(CITY) (STATE) (ZIP CODE)

AUTHORIZATION NUMBER: _____

AUTHORIZED SIGNATURE: _____

DATE: _____

****

MAIL TO: CJIS CENTRAL REPOSITORY, P.O. BOX 32708, PIKESVILLE, MD. 21282-2708
Customer Assistant Desk: (410) 764-4501 Fax#: 410-653-5690 Alt. Fax#: 410-653-6320

****

FOR CJIS CENTRAL REPOSITORY USE ONLY

This request can not be processed because:
_____this is not a valid reference number
_____this is not a valid authorization number
_____this reference number has not been received at the Central Repository
_____this authorization number is not approved for this request.
_____the application associated with this reference number was received more than 365 days before receipt of this request.
_____requested information is not completed

- Use for individuals who were fingerprinted for child care within last year
- Does not require fingerprints
- No charge

CPS Background Clearance

- All employees must complete CPS Release of Information Form (DHR/SSA 1279) online.
- Handwritten forms are not accepted.
- Personnel Administrator keeps original signed and notarized form on file at camp.
- Personnel Administrator must “Submit” and Complete online via myDHR site.
- CPS Background Clearance result is received via email from myDHR site or can be viewed on the site.
- Personnel Administrator’s original signed and notarized form is sent to MDH (not DHS).

Reviewing Results

COMAR 10.16.06.21

- Personnel Administrator must review MD and FBI background checks and CPS background clearance information.

- Cannot employ an individual with a conviction, probation before judgment, not criminally responsible disposition or pending charge listed in Regulation .21E.

- Per Regulation .21F, if results indicate that the individual is responsible for child abuse/neglect or includes a crime not included in .21E, then Personnel Administrator must assess hiring based on job position, nature/seriousness of the crime, how long ago, individual's age, probation/parole and other pertinent information.

Procedures

Emergency Procedures

- Regulation 10.16.06.34

Trip and Transportation

- Regulations 10.16.06.52, and .53

Supervision during routine activities

- Regulation 10.16.06.54

Specialized Activities

- Regulations 10.16.06.47, through .52

Child Abuse Prevention and Reporting

- Regulation 10.16.06.35

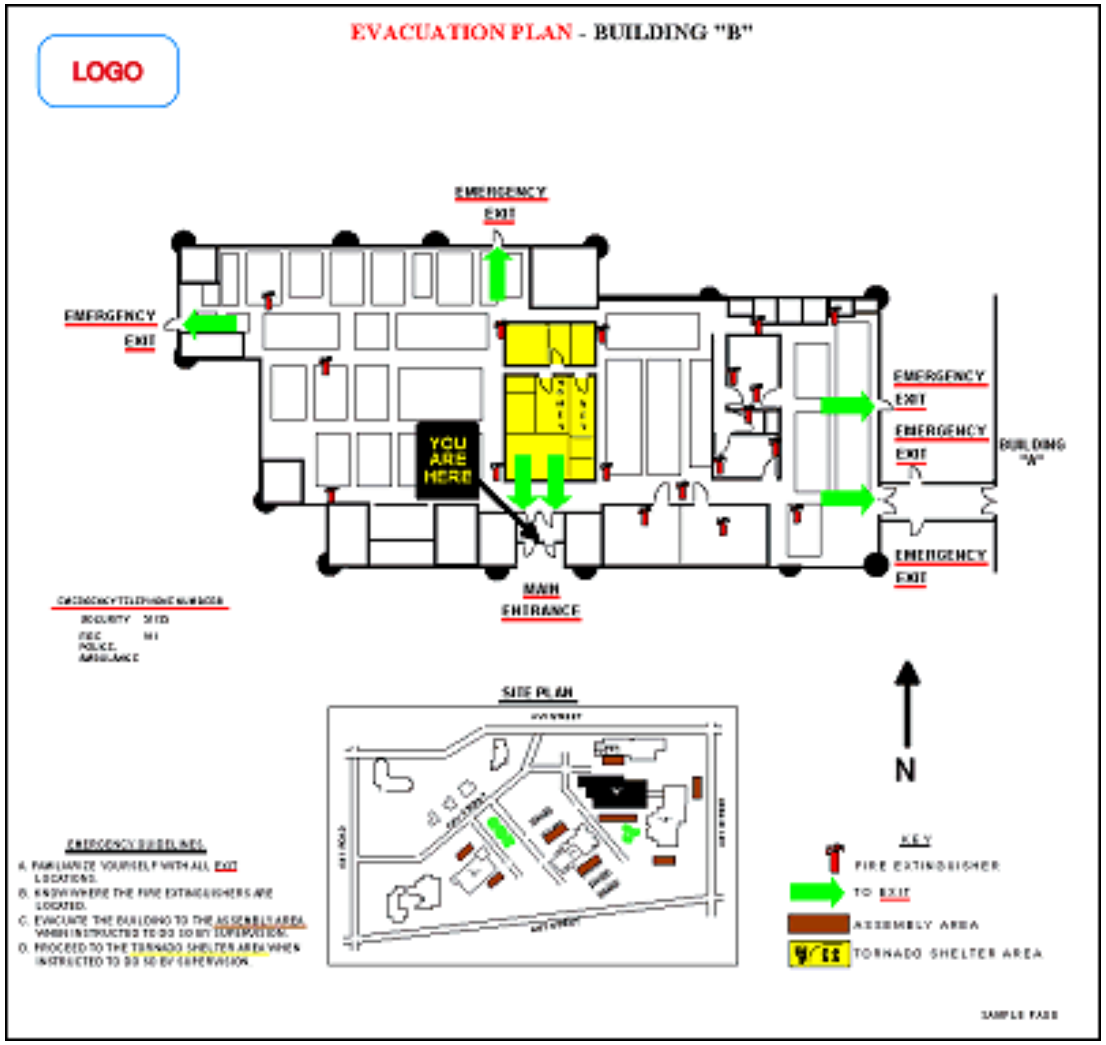
Regulation 10.16.06.34

– Natural disasters and severe weather

– Being prepared

MARYLAND Department of Health

Evacuation Plan



Where are you going?
Practice drills and document them at the beginning of each new session or whenever new children are added.

MARYLAND Department of Health

Missing Campers?

1

2

3

4

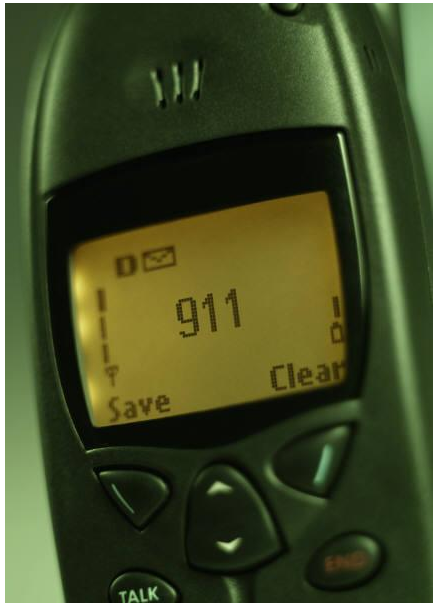
5

6 ?

- Head count,
- Missing campers,
- Finding missing campers.

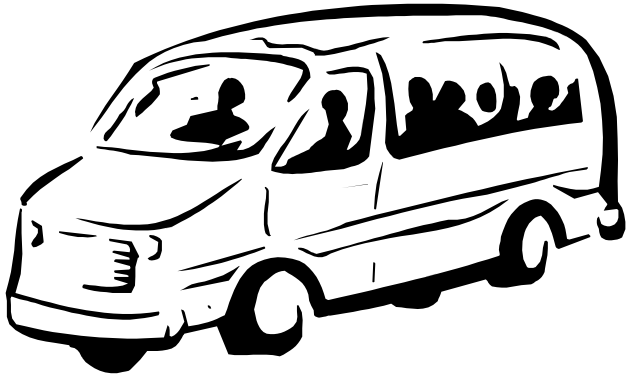
911

- Does camp use cell phones or another communication plan?
- Who is responsible for calling 9-1-1?



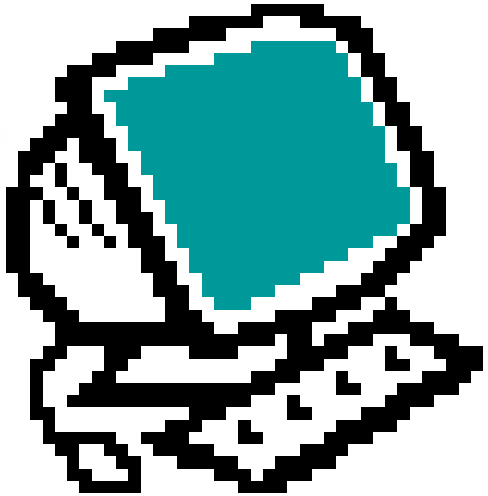
Transportation for Evacuation

- Emergency transportation plan for evacuating the entire facility.



Notify Parents

- Mechanisms for notifying parents of changes to pick-up or drop-off locations due to an emergency situation.



Ensure Camper Safety

- Maintain the safety of the other campers while searching for a missing camper.

Regulation 10.16.06.52 and .53

- Written Safety Plans for:
  - Field trips (See Handout)
  - Transportation (See Handout)
    - Safety Seats for Younger Children
- Written parental authorization
- Rules
- Supervision

Specialized Activities

Regulation 10.16.06.47 - .52

- All Specialized Activities
  - Director Present
  - Safety Plan Developed and Implemented
  - Staff Training
  - Staff Ratio (1 staff to 10 campers)
- Swimming
  - Swim ability test
  - Safety system to quickly account for campers
  - WATCHERS, WATCHERS, WATCHERS
- Marksmanship
- Horseback Riding

Change to Regulation .51

- A helmet is required for rock climbing or high ropes activities, except when an auto-belay system is utilized.

Supervision

Regulation 10.16.06.54

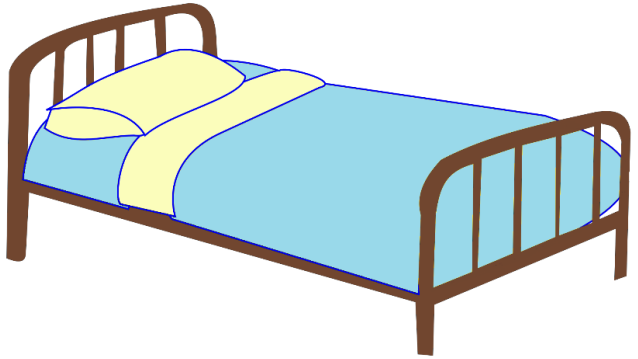
Campers	Required Number of Adults and Assistant Counselors	
	Adults	Assistant Counselors or Adults
3 ½ to 5 years old		
1 to 8	1	0
9 to 16	1	1
17 to 24	1	2
6 to 10 years old		
1 to 15	1	0
16 to 30	1	2
	Or 2	0
11 years old or older		
1 to 15	1	0
16 to 30	1	2
	Or 2	0
31 to 40	2	2
	Or 3	0

Mandated Reporters

Regulation 10.16.06.35

- Develop and implement child abuse prevention and reporting plan
  see handout
- Recognizing signs of abuse and neglect
- Provide training to staff members/volunteers on the prevention and reporting plan annually
- Keep sign-in sheet for training on file
- Keep a copy of the local DSS numbers on file
- Child abuse reporting legal requirements, have copy of form
- Reporting responsibility rests upon the person who suspects the abuse.
- Report to Director/Owner?
- Developing a Child Abuse Prevention and Reporting Plan handout.

Regulations 10.16.06.38 - .41



Regulations 10.16.06.38 - .40

- Toilet facilities: If separate toilet facilities are provided they must be properly marked
- Showerheads spaced min. of 30 inches apart
- Min. of 6 square feet of floor area
- Constructed of nonabsorbent, skid resistant, easily cleanable material
- Min. temp 90°F max. temp 120°F

Type of Facility	Day	Residential
1 Toilet per	35 campers	15 campers
1 Hand Washing Unit per	35 campers	25 campers
1 Showerhead per	N/A	15 campers
1 Bed, Cot or Bunk per	N/A	1 camper

- Sleeping facilities, COMAR 10.16.06.40
- 1 bed, cot, or bunk per camper
- Sturdy frame with 12 inches from floor
- Clean, vermin-free, hole-free mattress plastic mattress cover
- Disinfect mattresses annually
- Provide min. of 30 square feet of floor space per occupant in sleeping areas
- Double Bunks: 27 inches bottom bunk to top bunk and 36 inches top bunk to ceiling

Garbage removal, COMAR 10.16.06.43

- Durable containers in good repair
- Collected as necessary to prevent overflow
- Disposed of legally
- Outside containers have:
  - Tight-fitting Lids
  - Are leak-proof, fly-proof, and rodent-proof

Insect and rodent control

COMAR 10.16.06.44

- Minimize entry
- Eliminate harborage

MARYLAND Department of Health

Documentation for Private Building

- Building — COMAR 10.16.06.46
  - Use and Occupancy Permit
    Or
  - Master Plumber and Master Electrician Letters
- Water and Sewage — COMAR 10.16.06.36
  - Public Water and Sewer — COMAR 10.16.06.37
    Or
  - Local Health Approval Form — COMAR 10.16.06.46
- Fire Marshal Inspection
- Food Service Facility Permit from LHD — COMAR 10.16.06.42
- Swimming Pool Permit from LHD — COMAR 10.16.06.47

Documentation for School/Government

- Building Safety Form
  - Covers:
    - Water
    - Sewage Disposal
    - Plumbing
    - Electrical
    - Fire
    - Building/Zoning
- Food Service Facility Permit from LHD
- Swimming Pool Permit from LHD

Health Supervisor

COMAR 10.16.07.04

- Doctor
- Nurse
- Certified Nurse Practitioner

- **Duties**
  - Review & Approve Health Program Annually
  - Oversee or Delegate Medication Administration
  - Oversee Health Treatment Area
  - Review Camper Health Forms

CPR/First Aid

COMAR 10.16.07.04

- Minimum of 2 Adults
  - Certification Issued by National Organization
- On Duty at All Times
  - From 1st camper arrival to last camper pick up
- Field Trips
  - One with trip and one at camp if campers stay behind

Written Health Program

COMAR 10.16.07.03

Refer to list of questions provided in your packet.

Medications

COMAR 10.16.07.14

- Covers Prescription and Nonprescription Medications
- Delegation ability varies depending on credentials of Health Supervisor
- Self-administration vs. Staff Administration
- Youth Camp Medication Administration Certificate Holder

Medications

COMAR 10.16.07.14

- Prescriptive Order for All Medication – MDH form
  - (may be used at multiple camps for one season)
- Parental Consent Documented
- Standing Orders and Parental Consent
- Staff Medications
- Sunscreen, see January 25, 2017 memo

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- Applicant = Someone that:

1) Operates a youth camp

2) Is at least 18 years old

3) Has successfully completed an emergency epinephrine training program approved by the department.

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

The applicant may apply to the Department for a Certificate for Emergency Epinephrine by submitting a written policy that includes:

1) Designation of agents

2) The name of the approved emergency epinephrine educational training program

3) Procedures to:

a) Store the epi pen

b) Notify parents it is available

c) Maintain epi pen in secure manner

d) Report use of epi pen according to .06

e) Train certificate holder and agent annually

f) Keep training docs. for 3 years

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- An emergency epinephrine educational training program shall include:

1) The signs and symptoms of anaphylaxis

2) Use of an emergency auto-injectable epinephrine pen

3) Follow-up procedures with a parent or guardian after an emergency auto-injectable epinephrine is administered

4) A skills demonstration

5) A written examination

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- An individual teaching an emergency epinephrine educational training program shall be licensed as a physician, a register nurse, or a certified nurse practitioner.

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- A certificate for emergency epinephrine holder may:

1) On presentment of a certificate for emergency epinephrine, receive from any physician licensed to practice medicine in the State a prescription for auto-injectable epinephrine; and

2) Possess and store prescribed auto-injectable epinephrine

(Optional) Emergency Epinephrine

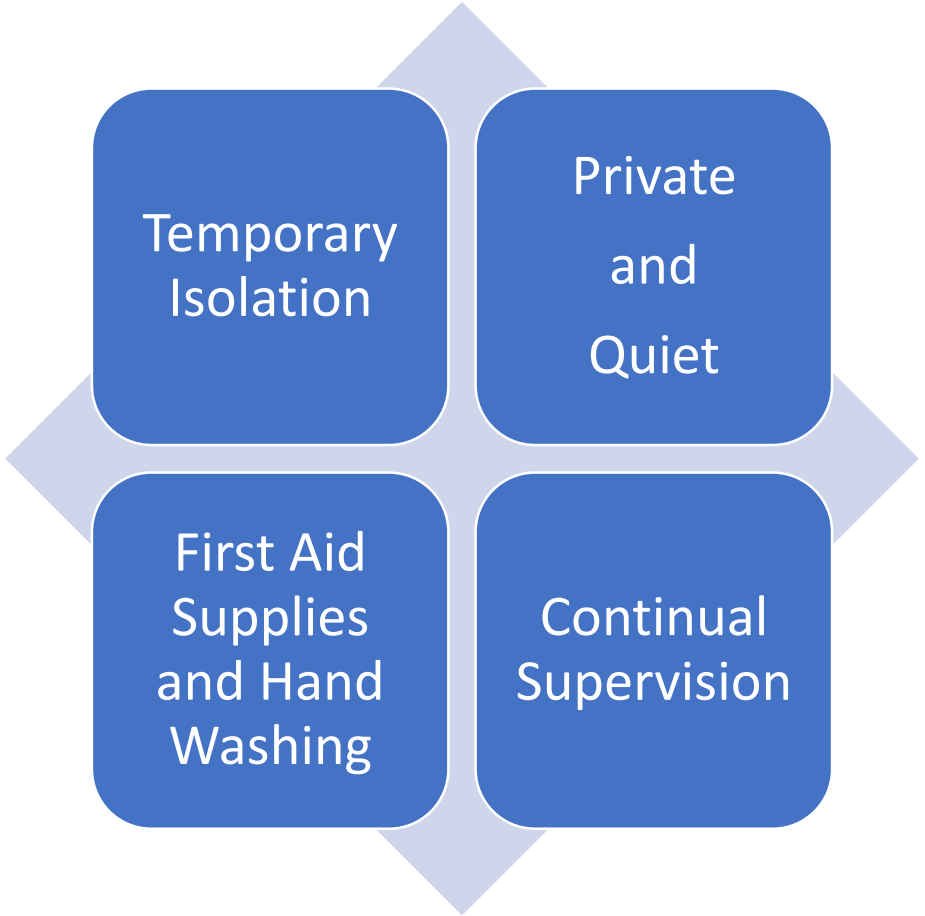
COMAR 10.16.07.15

In an emergency, a certificate for emergency epinephrine holder or agent may administer auto-injectable epinephrine to an individual who is experiencing or believed in good faith by the certificate holder or agent to be experiencing anaphylaxis.

Treatment Area

COMAR 10.16.07.13

Day Camp



Treatment Area

COMAR 10.16.07.13

Residential Camp

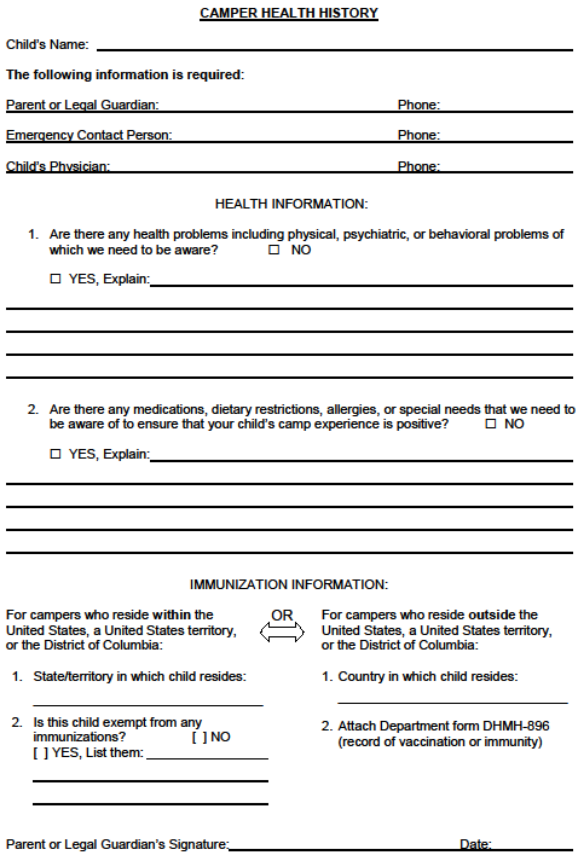
Health Program

Health Records

COMAR 10.16.07.08 & .09

Camper Health Record

Staff/Volunteer Health Record



CAMPER HEALTH HISTORY

Child's Name: _____

The following information is required:

Parent or Legal Guardian: _____ Phone: _____

Emergency Contact Person: _____ Phone: _____

Child's Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

2. Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive? ☐ NO

   ☐ YES, Explain: _____

IMMUNIZATION INFORMATION:

For campers who reside **within** the United States, a United States territory, or the District of Columbia:

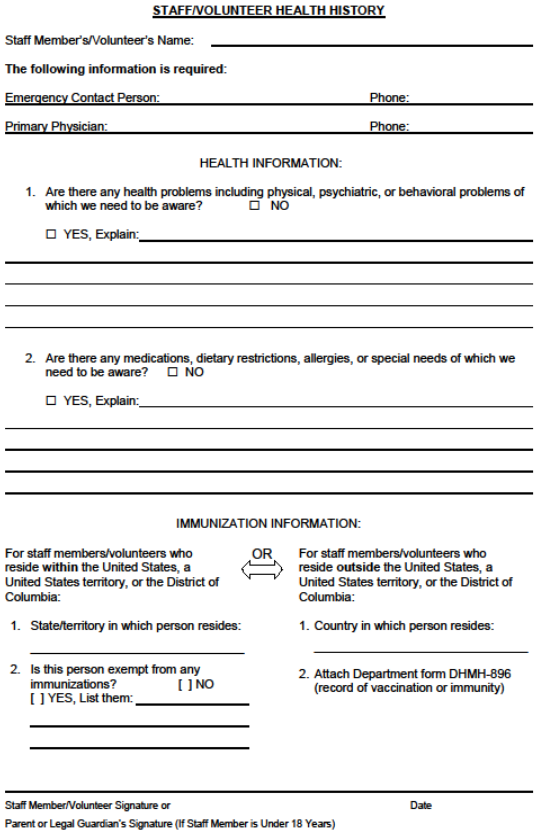
1. State/territory in which child resides: _____
2. Is this child exempt from any immunizations? [ ] NO
   [ ] YES, List them: _____

OR

For campers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. Country in which child resides: _____
2. Attach Department form DHMH-896 (record of vaccination or immunity)

Parent or Legal Guardian's Signature: _____ Date: _____



STAFF/VOLUNTEER HEALTH HISTORY

Staff Member's/Volunteer's Name: _____

The following information is required:

Emergency Contact Person: _____ Phone: _____

Primary Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

2. Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

IMMUNIZATION INFORMATION:

For staff members/volunteers who reside **within** the United States, a United States territory, or the District of Columbia:

1. State/territory in which person resides: _____
2. Is this person exempt from any immunizations? [ ] NO
   [ ] YES, List them: _____

OR

For staff members/volunteers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. Country in which person resides: _____
2. Attach Department form DHMH-896 (record of vaccination or immunity)

Staff Member/Volunteer Signature or Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years) _____ Date

MARYLAND Department of Health

Health Log

COMAR 10.16.07.15

Must Include:

1. Date
2. Name of Camper
3. Ailment
4. Treatment Prescribed
5. Name or Initials of Person Administering Care

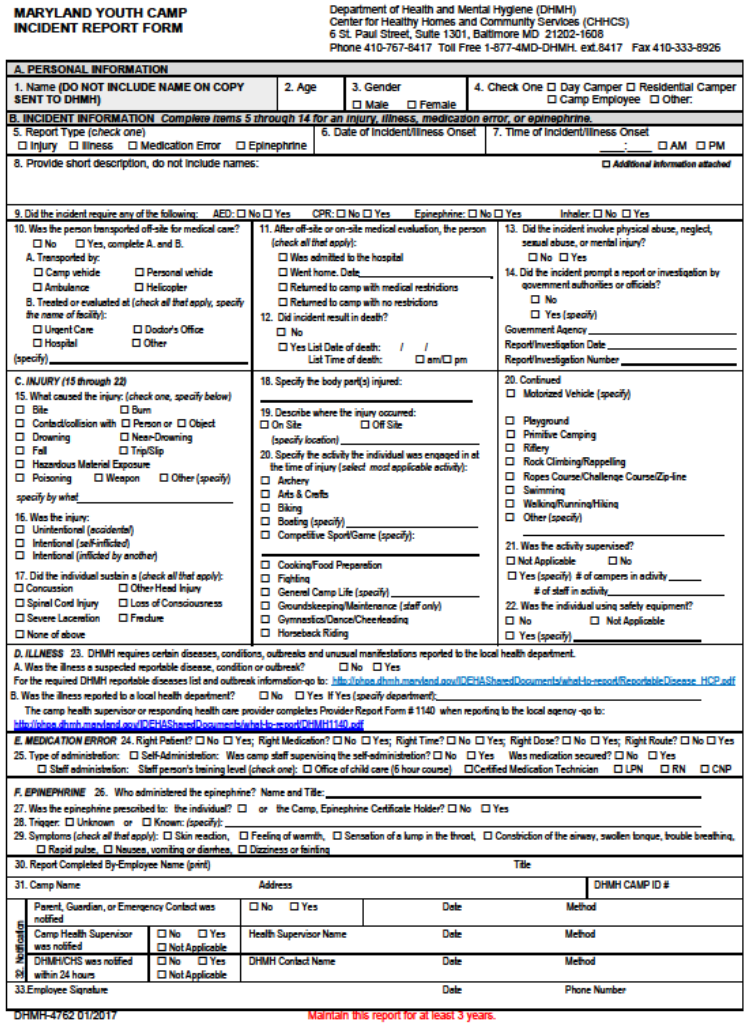
Must Be:

1. On Lined Paper
2. Kept Confidential
3. In Locked Compartment
4. Available to Department
5. Retained for 3 years
6. Recorded in Ink
7. No Skipped Lines
8. Spiral Book Must Have Sequentially Numbered Pages

Health Program

Incident Report

COMAR 10.16.07.06 & .07



MARYLAND YOUTH CAMP
INCIDENT REPORT FORM

Department of Health and Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301, Baltimore MD 21202-1608
Phone 410-767-8417 Toll Free 1-877-4MD-DHMH. ext.8417 Fax 410-333-8926

A. PERSONAL INFORMATION

1. Name (DO NOT INCLUDE NAME ON COPY SENT TO DHMH)	2. Age	3. Gender ☐ Male ☐ Female	4. Check One ☐ Day Camper ☐ Residential Camper ☐ Camp Employee ☐ Other:

B. INCIDENT INFORMATION *Complete items 5 through 14 for an injury, illness, medication error, or epinephrine.*

5. Report Type (check one) ☐ Injury ☐ Illness ☐ Medication Error ☐ Epinephrine	6. Date of Incident/Illness Onset	7. Time of Incident/Illness Onset ____:____ ☐ AM ☐ PM

8. Provide short description, do not include names: ☐ Additional information attached

9. Did the incident require any of the following: AED: ☐ No ☐ Yes CPR: ☐ No ☐ Yes Epinephrine: ☐ No ☐ Yes Inhaler: ☐ No ☐ Yes

10. Was the person transported off-site for medical care?
☐ No ☐ Yes, complete A. and B.
A. Transported by:
☐ Camp vehicle ☐ Personal vehicle
☐ Ambulance ☐ Helicopter
B. Treated or evaluated at (*check all that apply, specify the name of facility*):
☐ Urgent Care ☐ Doctor's Office
☐ Hospital ☐ Other
(specify) _____

11. After off-site or on-site medical evaluation, the person (*check all that apply*):
☐ Was admitted to the hospital
☐ Went home. Date_____
☐ Returned to camp with medical restrictions
☐ Returned to camp with no restrictions

12. Did incident result in death?
☐ No
☐ Yes List Date of death: / /
List Time of death: ☐ am/☐ pm

13. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury?
☐ No ☐ Yes

14. Did the incident prompt a report or investigation by government authorities or officials?
☐ No
☐ Yes (specify)
Government Agency _____
Report/Investigation Date _____
Report/Investigation Number _____

C. INJURY (15 through 22)

15. What caused the injury: (*check one, specify below*)
☐ Bite ☐ Burn
☐ Contact/collision with ☐ Person or ☐ Object
☐ Drowning ☐ Near-Drowning
☐ Fall ☐ Trip/Slip
☐ Hazardous Material Exposure
☐ Poisoning ☐ Weapon ☐ Other (*specify*)
*specify by what*_____

16. Was the injury:
☐ Unintentional (*accidental*)
☐ Intentional (*self-inflicted*)
☐ Intentional (*inflicted by another*)

17. Did the individual sustain a (*check all that apply*):
☐ Concussion ☐ Other Head Injury
☐ Spinal Cord Injury ☐ Loss of Consciousness
☐ Severe Laceration ☐ Fracture
☐ None of above

18. Specify the body part(s) injured:
_____

19. Describe where the injury occurred:
☐ On Site ☐ Off Site
(*specify location*) _____

20. Specify the activity the individual was engaged in at the time of injury (*select most applicable activity*):
☐ Archery
☐ Arts & Crafts
☐ Biking
☐ Boating (*specify*) _____
☐ Competitive Sport/Game (*specify*): _____
☐ Cooking/Food Preparation
☐ Fighting
☐ General Camp Life (*specify*) _____
☐ Groundskeeping/Maintenance (*staff only*)
☐ Gymnastics/Dance/Cheerleading
☐ Horseback Riding

20. Continued
☐ Motorized Vehicle (*specify*)
_____
☐ Playground
☐ Primitive Camping
☐ Riflery
☐ Rock Climbing/Rappelling
☐ Ropes Course/Challenge Course/Zip-line
☐ Swimming
☐ Walking/Running/Hiking
☐ Other (*specify*)
_____

21. Was the activity supervised?
☐ Not Applicable ☐ No
☐ Yes (*specify*) # of campers in activity _____
# of staff in activity_____

22. Was the individual using safety equipment?
☐ No ☐ Not Applicable
☐ Yes (*specify*) _____

D. ILLNESS 23. DHMH requires certain diseases, conditions, outbreaks and unusual manifestations reported to the local health department.
A. Was the illness a suspected reportable disease, condition or outbreak? ☐ No ☐ Yes
For the required DHMH reportable diseases list and outbreak information-go to: http://phpa.dhmh.maryland.gov/IDEHASharedDocuments/what-to-report/ReportableDisease_HCP.pdf
B. Was the illness reported to a local health department? ☐ No ☐ Yes If Yes (*specify department*):_____
The camp health supervisor or responding health care provider completes Provider Report Form # 1140 when reporting to the local agency -go to:
http://phpa.dhmh.maryland.gov/IDEHASharedDocuments/what-to-report/DHMH1140.pdf

E. MEDICATION ERROR 24. Right Patient? ☐ No ☐ Yes; Right Medication? ☐ No ☐ Yes; Right Time? ☐ No ☐ Yes; Right Dose? ☐ No ☐ Yes; Right Route? ☐ No ☐ Yes
25. Type of administration: ☐ Self-Administration: Was camp staff supervising the self-administration? ☐ No ☐ Yes Was medication secured? ☐ No ☐ Yes
☐ Staff administration: Staff person's training level (*check one*): ☐ Office of child care (6 hour course) ☐Certified Medication Technician ☐ LPN ☐ RN ☐ CNP

F. EPINEPHRINE 26. Who administered the epinephrine? Name and Title: _____
27. Was the epinephrine prescribed to: the individual? ☐ or the Camp, Epinephrine Certificate Holder? ☐ No ☐ Yes
28. Trigger: ☐ Unknown or ☐ Known: (*specify*): _____
29. Symptoms (*check all that apply*): ☐ Skin reaction, ☐ Feeling of warmth, ☐ Sensation of a lump in the throat, ☐ Constriction of the airway, swollen tongue, trouble breathing, ☐ Rapid pulse, ☐ Nausea, vomiting or diarrhea, ☐ Dizziness or fainting

30. Report Completed By-Employee Name (print) Title

31. Camp Name Address DHMH CAMP ID #

Notification					
	Parent, Guardian, or Emergency Contact was notified	☐ No ☐ Yes		Date	Method
	Camp Health Supervisor was notified	☐ No ☐ Yes ☐ Not Applicable	Health Supervisor Name	Date	Method
	DHMH/CHS was notified within 24 hours	☐ No ☐ Yes ☐ Not Applicable	DHMH Contact Name	Date	Method

33.Employee Signature Date Phone Number

DHMH-4762 01/2017 Maintain this report for at least 3 years.

MARYLAND Department of Health

Acute Illness & Communicable Disease

COMAR 10.16.07.12

Refer to list provided in your packet.

Staff Training & Certification

- Training
  - Document staff training for the following:
    - Health Program
      - Including Medication Administration
    - Emergency Plan
    - Trip Safety Plan
    - Transportation Safety Plan
    - Specialized Activities Safety Plans
    - Child Abuse Prevention and Reporting

- CPR and First Aid certification
  - Document current CPR/first aid
  - Ensure that at least 2 adults with CPR/FA are on duty during camp

Submitting Required Reports

- COMAR 10.16.06.06 and COMAR 10.16.07.06

- Annual Report must be submitted to Center for Healthy Homes and Community Services within 4 weeks of camp ending along with any required injury/illness reports.

Submitting Required Reports

- Submit Annual Report and Incident Report online.

  https://mdhyouthcamps.force.com/login

- **Obtain a user name from MDH**
- Create a password
- See instructions in Welcome to Youth Camps Online
- Online renewal

Questions?